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**Lest we forget: Comparing retrospective and prospective assessments of adverse childhood experiences in the prediction of adult health**

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Key Words:	Adversity, Early life experience, Developmental epidemiology, Health, Longitudinal studies

**Lest we forget:  
Comparing retrospective and prospective assessments of  
adverse childhood experiences in the prediction of adult health**

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## Abstract

**Background.** Adverse childhood experiences (ACEs; e.g., abuse, neglect, parental loss, etc.) have been associated with increased risk for later-life disease and dysfunction using adults' retrospective self-reports of ACEs. Research should test whether associations between ACEs and health outcomes are the same for prospective and retrospective ACE measures.

**Methods.** We estimated agreement between ACEs prospectively-recorded throughout childhood (by Study staff at Study member ages 3, 5, 7, 9, 11, 13, and 15) and retrospectively-recalled in adulthood (by Study members when they reached age 38), in the population-representative Dunedin cohort (N=1,037). We related both retrospective and prospective ACE measures to physical, mental, cognitive, and social health at midlife measured through both objective (e.g., biomarkers and neuropsychological tests) and subjective (e.g., self-reported) means.

**Results.** Dunedin and CDC ACE distributions were similar. Retrospective and prospective measures of adversity showed moderate agreement ( $r=.47$ ,  $p<.001$ ; weighted Kappa = .31, 95% CI: .27-.35). Both associated with all midlife outcomes. As compared to prospective ACEs, retrospective ACEs showed stronger associations with life outcomes that were subjectively assessed, and weaker associations with life outcomes that were objectively assessed. Recalled ACEs and poor subjective outcomes were correlated regardless of whether prospectively-recorded ACEs were evident. Individuals who recalled more ACEs than had been prospectively recorded were more neurotic than average, and individuals who recalled fewer ACEs than recorded were more agreeable.

**Conclusions.** Prospective ACE records confirm associations between childhood adversity and negative life outcomes found previously using retrospective ACE reports. However, more agreeable and neurotic dispositions may respectively bias retrospective ACE measures toward underestimating the impact of adversity on objectively-measured life outcomes and overestimating the impact of adversity on self-reported outcomes. [Associations between personality factors and the propensity to recall adversity were extremely modest and warrant further investigation.](#) Risk predictions based on retrospective ACE reports should utilize objective outcome measures. Where objective outcome measurements are difficult to obtain, correction factors may be warranted.

**Key words.** Adverse childhood experiences, physical health, mental health, cognitive health, epidemiology

Introduction

In the quest to predict and prevent the development of hard-to-treat and costly later-life diseases, childhood has emerged as a key window of risk determination (Weintraub et al., 2011). In particular, childhood exposures to adverse conditions, including abuse, neglect, and family dysfunction, have been linked to numerous physical diseases and psychological problems (Felitti et al., 1998; Anda et al., 2006; Wilson et al., 2006; Afifi et al., 2008; Benjet, Borges, & Medina-Mora, 2010; Green et al., 2010; Scott et al., 2011; Varese et al., 2012; Solís et al., 2015). These associations are hypothesized to result from alterations in health-risk behaviors (e.g., increased drug use to cope with distress) and/or physiological reactions to chronic stress (Felitti, 2009; Danese & McEwen, 2012). They follow a dose-response relationship; exposure to more adversities forecasts poorer health (Felitti et al., 1998). Public health advocates have called childhood adversity a "hidden health crisis" with "far reaching consequences" (Center for Youth Wellness, 2014, p.1). Such is the concern over the consequences of childhood adversity that many states in the U.S. now monitor for childhood adversity among adults through an Adverse Childhood Experience (ACE) module, provided by the U.S. Center for Disease Control (CDC) in Behavioral Risk Factor Surveillance System surveys (Austin & Herrick, 2014 May).

To date, evidence linking ACEs with adult health comes primarily from studies that measure adults' recollections of childhood adversity. The validity of such retrospective reports has been questioned because of possible misclassification and bias. On the one hand, adult participants may not be able to retrieve episodic memory from their early years (so called infantile amnesia; Pillemer & White, 1989; Usher & Neisser, 1993) and may fail to correctly retrieve episodic memory from their distant past, particularly at older ages (Hänninen &

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Soininen, 2012). On the other hand, adult participants may be more or less likely to report childhood adversity based on individual features. For example, they may choose not to divulge intimate information to avoid distress or embarrassment (Hardt & Rutter, 2004). Alternatively, the presence of disease, psychopathology or certain personality styles may unconsciously increase an individual's propensity to recall childhood adversity –artificially linking childhood experience and adult disease outcomes (Matt, Vazquez, & Campbell, 1992; Henry, Moffitt, Caspi, Langley, & Silva, 1994; McFarland & Buehler, 1998; Prescott et al., 2000; Susser & Widom, 2012; Colman et al., 2016). Although prospective measures of childhood adversity are less sensitive to bias linked to individual features, their validity may nevertheless be limited because of other sources of misclassification including under-reporting by caregivers or under-detection by agencies (Hardt & Rutter, 2004).

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The goal of our study was to compare retrospective and prospective measures of ACEs in the prediction of later-life disease and dysfunction. Poor adult health and social outcomes have been associated with prospectively measured ACEs (Solís et al., 2015). However, to our knowledge only one previous comparison of outcome predictions from retrospective and prospective measures of ACEs in the same sample has been undertaken (Patten et al., 2015). Past comparisons of retrospective and prospective reports of child maltreatment raised concern that these two forms of measurement do not match and, further, do not predict outcomes equally (e.g., Widom & Engel, 1996; Widom & Morris, 1997; Horwitz, Widom, McLaughlin, & White, 2001), although at least one study has reported low agreement between measures but similar prediction of mental-health outcomes (Scott, McLaughlin, Smith, & Ellis, 2012). Furthermore, evidence suggests that retrospective reports of ACEs are inconsistent over time, depending on psychological distress at the time of recall (Colman et al., 2016). Here we compare the

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associations among retrospective and prospective measures of ACEs and physical, cognitive, mental and social health outcomes. Based on previous literature (e.g., Hardt & Rutter, 2004), we predicted that our prospective and retrospective ACE measures would show moderate agreement and that both would associate with later-life outcomes. We conducted our comparison in the Dunedin Study, a population-representative longitudinal birth-cohort born in the early 1970s and followed to early midlife. Prospective ACE counts were generated from dossiers that we compiled for each Study member, which contained information drawn from Study staff assessments and observations, parent and teacher reports, and evidence of social service contacts collected at Study member ages 3, 5, 7, 9, 11, 13, and 15). Retrospective ACE counts were generated from Study member recollections of childhood adversity reported in adulthood.

In addition to potential discrepancies between retrospectively-recalled and prospectively-recorded ACEs, we anticipated differences in associations of ACE measures with outcomes that are objectively measured as compared to those that are measured subjectively (i.e., through self-report). Health-psychology research has documented that self-reports tend to be suffused with biases stemming from reporters’ personality styles, like neuroticism, while objective measures are not (Watson & Pennebaker, 1989). We therefore tested both objective and subjective outcomes measurements.

Finally, because personality styles may also influence recall of ACEs, we tested if reporters’ personality styles were associated with discrepant retrospectively-recalled and prospectively-recorded ACE exposures.

## Methods

### *Sample*

Participants are members of the Dunedin Study, a longitudinal investigation of health and behavior in a representative birth cohort. Study members (N=1,037; 91% of eligible births; 52% male) were all of the individuals born between April 1972 and March 1973 in Dunedin, New Zealand (NZ), who were eligible based on residence in the province and who participated in the first assessment at age 3. The cohort represented the full range of socioeconomic status (SES) in the general population of New Zealand's South Island. On adult health, the cohort matches the New Zealand National Health and Nutrition Survey on key health indicators (e.g. body mass index, smoking, visits to the doctor; Poulton et al. 2015). The cohort is primarily white; fewer than 7% self-identify as having non-Caucasian ancestry, matching the demographics of the South Island (Poulton et al., 2015). Assessments were carried out at birth and ages 3, 5, 7, 9, 11, 13, 15, 18, 21, 26, 32, and, most recently, 38 years, when 95% of the 1,007 study members still alive took part. In the interest of reproducibility, the analysis plan for this paper was posted in advance (<http://www.moffittcaspi.com>; Trinh & Sun, 2013). Study member informed consent was obtained, with study protocol approval by the institutional ethical review boards of the participating universities.

### *Measures*

#### **Adverse childhood experiences (ACEs)**

The U.S. Centers for Disease Control & Prevention (CDC) have articulated a leading approach to conceptualizing ACEs (Felitti et al., 1998). Our measure of ACEs corresponds to the



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10 categories of childhood adversity introduced by the CDC Adverse Childhood Experiences Study (Felitti et al., 1998; <http://www.cdc.gov/violenceprevention/acestudy/prevalence.html>): Five types of child harm (physical abuse, emotional abuse, physical neglect, emotional neglect and sexual abuse) and five types of household dysfunction (incarceration of a family member, household substance abuse, household mental illness, loss of a parent, and household partner violence). Because the Dunedin Study began in the early-1970s and the awareness of ACEs in the health sciences dates to the mid-1990s, Dunedin Study operational definitions of retrospective and prospective ACEs were necessarily somewhat different.

***Retrospective ACE counts***

The ACE Study collects retrospectively recalled ACEs via a self-report questionnaire (<http://www.cdc.gov/violenceprevention/acestudy/prevalence.html>). Our retrospective ACEs measure draws on structured interviews conducted when Dunedin Study participants were adults. Like the CDC ACE Study, we administered the Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink, 1998), which ascertains physical, sexual and emotional abuse, physical neglect, and emotional neglect; the CTQ was administered at age 38. Following the CTQ manual a specific category of harm was present if the Study member had a moderate to severe score. Study members were also interviewed about memories of exposure to family substance abuse, mental illness, and incarceration during childhood via the Family History Screen (Milne et al., 2009). Exposure to partner violence was assessed by asking Study participants, “Did you ever see or hear about your mother/father being hit or hurt by your father/mother/stepfather/stepmother?” We also interviewed participants about parental loss (due to separation, divorce, death, or removal from home).

### *Prospective ACE counts*

Prospective ACE counts were generated from archival Dunedin Study records gathered during 7 biennial assessments carried out from ages 3 to 15 years. The records include: social service contacts; structured notes from assessment staff who interviewed Study children and their parents; structured notes from pediatricians and psychometricians who observed mother-child interactions at the research unit; structured notes from nurses who recorded conditions witnessed at home visits; and notes of concern from teachers who were surveyed about the Study children's behavior and performance. Separately, parental criminality was surveyed via postal questionnaire to the parents. Attrition analysis found no significant difference in exposure to ACEs between those individuals who completed the Study assessment at age 38 and those who did not ( $\chi^2(4, N = 1034) = 7.36, p = .12$ ). Prospective ACEs data were missing for only 3 of the 1037 cohort members.

Archival Study data were reviewed in 2015 by four independent raters who were trained on the CDC definitions of ACEs. Individual ACEs were agreed upon by at least three of the four raters 80% of time. The sole exception was emotional neglect where half the cases were identified by only two raters. Agreement across the full ACE count between the four raters ranged from kappa = .76 to .82, with an average inter-rater agreement kappa of .79.

The completeness of archival Dunedin Study records of adversity varied by the type of ACE considered. Some ACEs (notably childhood sexual abuse) will have been under-detected to the extent that these experiences were not actively queried, reflecting assumptions in the 1970's that sexual abuse was exceedingly rare (Jenny, 2008). To ensure that potential under-detection in any ACE category did not bias the results of our analyses, we repeated the full suite of tests used in this study with each type of ACE iteratively removed from the total ACE count. As presented

in the Results section, these “leave-one-out” analyses produced no significant changes to the results.

*Prevalence of retrospective and prospective ACEs in the Dunedin cohort*

Each ACE type was coded as present (=1) or not, with a theoretical maximum of 10 ACEs. (Following the CDC ACE Study, scores were coded 0, 1, 2, 3, or 4+ for all analyses.) **Figure 1A** shows a similar, zero-inflated, distribution of ACEs in the Dunedin study whether ACEs were gathered retrospectively or prospectively. The Figure also documents that the Dunedin ACE distribution resembled that of the CDC ACE Study. According to retrospective reports our cohort experienced more ACEs than they did according to our prospective records. **Figure 1B** shows that prospective rates were lower than retrospective rates on many, though not all, types of adversity.

**Adult health and social outcomes**

We assessed four outcome domains: physical, cognitive, mental, and social health. In every domain, where possible, each outcome was measured both objectively and subjectively. **Table 1** describes the outcome measures, which have been previously published in the Dunedin study.

**Potentially biasing Big Five personality factors**

The Big Five were assessed at age 38 via informants (Israel et al., 2014). Study members nominated someone who knew them well; most were best friends, partners, or other family members, with a 97% response rate. These “informants” were mailed questionnaires asking them to describe the Study member using a brief version of the Big Five Inventory (Benet-Martínez & John, 1998), which assesses individual differences in: Extraversion ( $\alpha = 0.79$ ), Agreeableness ( $\alpha$

= 0.75), Neuroticism ( $\alpha = 0.83$ ), Conscientiousness ( $\alpha = 0.81$ ), and Openness to Experience ( $\alpha = 0.85$ ).

## Results

### *Do retrospective and prospective ACE measures agree?*

**Table 2** presents the correlation and agreement (Cohen's Kappa) coefficients between ACE scores measured retrospectively and prospectively. At the item level, agreement between retrospectively-recalled and prospectively-recorded adversities ranged from excellent (loss of parent) to poor (emotional abuse). At the scale level of total ACE count, the correlation between retrospective and prospective ACE scores was  $r = .47, p < .001$ , a moderate effect size. Precise agreement between the number of adverse experiences retrospectively-recalled and prospectively-recorded was fair (weighted Kappa = .31, 95% CI: .27 - .35). **Supplementary Table S1** shows the percentage of prospectively-measured ACEs that were retrospectively recalled and the percentage of retrospective ACEs that were prospectively-recorded. Further analyses showed the overall level of agreement between retrospective and prospective reports was dependent, in part, on the high level of agreement about parental loss. Agreement between retrospective and prospective reports was lower when parental loss was not a part of the ACE measure (**Supplementary Table S2**).

### *Do retrospective and prospective ACE measures predict later-life health and social outcomes?*

Despite only moderate agreement between retrospective and prospective ACE measures, both were associated with later-life outcomes (**Table 3**). Effect-sizes for associations between

prospective ACEs and adult outcomes were small and relatively uniform (from  $r=.11$  to  $r=.23$ , Table 3 Column One). In contrast, effect sizes for associations between retrospective ACEs and outcomes were more variable (Table 3 Column Three). Retrospective ACE associations with objectively-measured outcomes had smaller effect-sizes as compared to associations with subjectively-measured outcomes (e.g.,  $r=.07$  for biomarker-indexed poor physical health versus  $r=.18$  for self-reported poor physical health). The largest effect-sizes were for associations between retrospective ACEs and outcomes of a more psychological nature (mental and social health; e.g.,  $r=.40$  for psychopathology).

***Do beliefs about childhood adversity predict outcomes regardless of what adversities were prospectively recorded?***

We used multivariate linear regressions to test associations between retrospective ACE counts and adult outcomes while controlling for prospective ACE counts (Table 3). For subjectively-measured outcomes, retrospective ACEs remained a statistically-significant predictor even after accounting for prospective ACEs. In contrast, retrospective ACE associations with objectively-measured outcomes dropped to non-significance after adding controls for prospective ACEs (Table 3, Column 4). This pattern of results suggested that, regardless of what prospective childhood records indicated, individuals' beliefs that they experienced adversity appeared to be strongly related to their appraisals of their current life outcomes. The belief that one has experienced childhood adversity did not, however, necessarily relate to outcomes that were objectively measured once prospective adversities were taken into account.

***Do prospectively-recorded adversities predict outcomes regardless of beliefs about childhood adversity?***

We used multivariate linear regressions to test associations between prospective ACE counts and adult outcomes while controlling for retrospective ACE counts (Table 3). As column two in Table 3 shows, prospective ACE associations with all subjectively-measured outcomes dropped to non-significance after controlling for retrospective ACE counts. In contrast, prospective ACEs remained a statistically-significant predictor of objectively-measured outcomes after adding controls for retrospective counts. This pattern of results suggested two things. First, greater adversity in childhood was followed by poorer mid-life outcomes (e.g., poorer physical and cognitive health) regardless of whether or not the adversity was remembered. Second, individuals who did not recall their prospectively-recorded adversities when interviewed as adults tended not to make negative appraisals of their life outcomes.

***Were findings biased by potentially missing prospective ACEs?***

As noted earlier, sexual abuse may have been under-recorded in the prospective ACE data. Sexual abuse is thought to be especially harmful. To evaluate whether this under-detection could have biased associations between prospective ACEs and adult outcomes, we repeated our analyses with sexual abuse removed from the count of total retrospective and prospective ACEs. If false negatives for sexual abuse biased the prospective ACE associations with outcomes, the strength of outcome-associations for the two ACE measures should become more similar after removing sexual abuse from total ACE counts. We then also iteratively removed each additional ACE type from our total count in turn and re-ran the analyses. These leave-one-out tests did not change the results, suggesting that the overall results were unlikely to have been biased by

misclassification in any of the ACEs components. Results of leave-one-out tests are reported in the **Supplementary Figure S1**.

*Are personality factors linked to ACE reports?*

Our analysis suggested that ACE associations with adult outcomes depended on what was remembered from childhood in the case of some outcomes but not others. For objectively-measured adult outcomes (e.g. health measured using biomarker indices), prospectively-recorded childhood adversity that was not recalled by participants in adulthood nevertheless predicted poor adult outcomes. In contrast, prospectively-recorded adversities that were not recalled in adulthood were unrelated to adult outcomes measured by subjective self-reports. This suggested that self-reports of adult outcomes could be biased by some individuals taking an overly positive view of their childhood and adulthood. Further, adversity that was recalled but not prospectively-recorded predicted self-reports of poor health and memory problems that were not confirmed by objective outcome tests. This suggested that self-reports of adult outcomes could also be colored by some individuals taking an overly negative view of their childhood and adulthood.

We next tested for the potential influence of personality factors on adult ACE recall and an individual’s potential discrepancy between prospective and retrospective ACE counts. To quantify this discrepancy, we subtracted each participant’s prospective ACE exposure score from their retrospective ACE score to create a measure of directional divergence ranging from -10 to +10. Results showed that three personality traits were significantly linked to the discrepancy between retrospective and prospective data: Neuroticism ( $r=.10$ ,  $p=.004$ ), Conscientiousness ( $r=-.07$ ,  $p<.05$ ), and Agreeableness ( $r=-.09$ ,  $p<.01$ ). As illustrated in **Figure 2**, individuals scoring high on Neuroticism or low on Conscientiousness were likely to have recalled more ACEs than

were prospectively recorded and individuals scoring high on Agreeableness were likely to have recalled fewer ACEs than were prospectively recorded.

## Discussion

Our longitudinal analysis of the association between ACEs and adult health outcomes revealed five findings. First, we replicated the association between retrospective ACEs and adult health outcomes reported in previous studies. In fact, when we compare our effect sizes in Table 3 to effect sizes reported in Felitti et al.'s (1998) Table 8 (p.254-255) we find that they are very similar. For example, in individuals who recalled four or more ACEs, Felitti et al. reported an increased risk of poor self-rated health on the order of  $d = .44$  where we report  $d = .49$ . Second, consistent with observations from previous analyses of the agreement between prospective and retrospective measures of specific childhood adversities (Hardt & Rutter, 2004; Patten et al., 2015), we found that prospective and retrospective ACE measures in the Dunedin cohort agreed only modestly. Such modest agreement may raise eyebrows, but it should be interpreted in context. For example, it is common in the behavioral sciences to observe modest levels of agreement between different reporters (e.g., mother and teacher reports of child ADHD symptoms typically correlate around .30; Wolraich et al., 2004). Rather than suggesting that one reporter's information is invalid, this finding is interpreted to reflect that different reporters have access to complementary sources of information. By extension, it is possible that retrospective and prospective ACE measures may share something in common *and* also contain unique information. Modest agreement here may thus suggest that retrospective ACE measures be viewed as complementary to prospective measures, rather than as potentially invalid. Third, notwithstanding low agreement with the retrospective measures, both retrospective and



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prospective ACEs predicted adult outcomes. Fourth, retrospective ACE measures, in comparison to prospective measures, more strongly predicted adult outcomes when outcomes were measured subjectively (through self-report). Fifth, prospective ACE measures, in comparison to retrospective measures, more strongly predicted adult outcomes when outcomes were measured objectively (through tests and biomarkers).

These results suggest that, relative to prospective ACE measures, retrospective ACE measures *underestimate* the influence of childhood adversity on “objective” adult outcomes and *overestimate* the influence of childhood adversity on “subjective” outcomes. This is consistent with a recent review of the limitations of retrospective recall of childhood adversity, which noted that adult psychopathology is more strongly associated with retrospective self-reports of childhood abuse than with official records of abuse (Susser & Widom, 2012). The authors concluded that, “the most plausible interpretation [for this phenomenon] is that people who have more problems in adulthood look back on childhood and report more problems" (p.674). Our data support this conclusion across domains as diverse as physical, cognitive, mental and social health but also suggest that the opposite is true: people who do not recall problems in childhood also do not see themselves as having problems in adulthood. In our study, adult individuals with documented childhood adversity that they did not recall had objectively poorer physical health and cognitive ability but surprisingly were unlikely to self-rate their health or memory as poor. Thus, strong associations between recalled adversity and poor self-rated health may result both from individuals who over-recall ACEs and under-rate health *and* from individuals who under-report ACEs and over-rate health. This suggests caution for interpretation; for domains where self-reports are the only means of measurement and no “objective” diagnostic tests are

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3 available, a downward correction factor may be desirable for interpreting health risks based on  
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5 adult recollections of childhood adversity.  
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8       There is precedent for this finding. Past studies have found that negative mood or existing  
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10 psychological dysfunction at the time of recall results in negative recollection bias (Dalgleish &  
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12 Watts, 1990; Brewin, Andrews, & Gotlib, 1993; Brewin, Reynolds, & Tata, 1999). But “healthy”  
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14 individuals may create biases of their own. In a comparison of clinical records with adult  
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16 recollection of adversity, Robins et al. (1985) found that healthy adults were “more likely to deny  
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18 adverse information about early home life” than those with mental illness (p.31). The authors  
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20 suggested that “those who are without current problems tend to forget and forgive.” In a review  
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22 of similar findings, Hardt and Rutter (2004) concluded that recall bias can sometimes show “a  
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24 tendency for people with good functioning in adult life to forget early parental negativity”  
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26 (p.267). Colman et al. (2016) asked 7,466 young adults to report on childhood adversity on two  
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28 occasions separated by a twelve-year delay. They found that most participants forgot some  
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30 episodes of adversity that they had originally recalled –but those with the most psychological  
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32 distress at the time of second testing “forgot” the least. Perhaps “forgetting and forgiving” can  
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34 be both willful and adaptive (Anderson & Levy, 2009; Nørby, 2015).  
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42       Our data suggest that trait-level personality may influence the process of “forgetting and  
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44 forgiving.” For example, we found that more neurotic individuals tend to recall more ACEs than  
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46 their prospective records indicate and that more agreeable individuals tend to recall fewer ACEs  
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48 than their prospective records indicate. Further, we found that an individual’s recollection of  
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50 their youth relates to their self-appraisals but not necessarily to their actual performance on  
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52 objective tests once prospective ACE records are taken into account. Taken together these  
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54 findings suggest that “grey” and “sunny” dispositions could be biasing both memories of  
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childhood and self-appraisals of adulthood in a manner that exaggerates the predictive capacity of retrospective ACE measures. Further research on this phenomenon is warranted, however, as our analysis on this point was only suggestive. First, the effect sizes for personality associations with divergent ACE counts in our study were very small. Second, our design, which measured Study member personality factors *after* potential exposure to ACEs, did not allow for the evaluation of cause-and-effect in the relationship between childhood adversity and adult personality (e.g., we are unable to disentangle the extent to which negative emotionality in adulthood is caused by childhood adversity or merely relates to the recall of adversity).

An additional contribution of our study is the finding that the imprint of childhood adversity maintains even when adversity is not recalled. We found that prospectively-recorded adversity that an individual does not recall still results in demonstrable detriments to their physical and cognitive health. Critically, these detriments were only detected through “objective” tests that do not rely on self-evaluation of abilities or self-awareness of poor functioning.

We acknowledge limitations. First, we only examined ACEs as defined in the original ACE study (Felitti et al., 1998), and not “Expanded ACEs” (Cronholm et al., 2015; Wade et al., 2015). Second, our aggregation of ACE events across the first 15 years of life precluded testing the influence of developmental timing or duration of adversity. Third, our findings may not be representative of the recall reliability of elderly populations, who often evidence poor memory (Hänninen & Soininen, 2012) and positive-event recall bias (Ros & Latorre, 2010). Finally, it is possible that our prospective ACE measures under-detected events of child harm, particularly sexual abuse. Our comparison of prospective and retrospective ACEs was not, therefore, a perfect one, because the mapping of the retrospective and prospective assessment was not exact. Yet, as far as we are aware, it was as complete as any other yet reported. Importantly, evidence

suggests that most prospective records of childhood sexual abuse, including official court records, tend to under-detect events (Hardt & Rutter, 2004) and could benefit from the addition of retrospective measures (Shaffer, Huston, & Egeland, 2008).

## Conclusion

Notwithstanding its limitations, our study holds several implications. Experienced adversity, whether it is recalled or not, increases risk for poor physical and cognitive health at midlife. Psychological resilience to adversity thus may not confer physiological resilience (Seery, 2011; Whitson et al., 2016), and primary care clinics using retrospective ACE reports to screen for high-risk patients may overlook individuals at-risk from ACEs that they experienced but do not remember. Meanwhile, the strong association between recalled adversity and self-rated health and social outcomes suggests a bias of both under- and over-reporting. Future studies on the influence of recalled childhood adversity on later-life outcomes should take pains to include outcome measures that are obtained objectively (e.g., Juonala et al., 2016). Sometimes objective measures are not available. This is especially true in the case of mental health. We would not advise clinicians to respond to reports of childhood adversity or perceived current malaise with suspicion—or for researchers to dismiss such valuable data. But neither would we advocate for uncritical acceptance of recollections of childhood as having purely causal implications for health.

The conceptualization of childhood adversity as a risk factor for later disability represents a powerful tool for identifying individuals at risk and, potentially, for developing targeted interventions (Garg & Dworkin, 2016). Our study confirms that the maltreatment and deprivation of the child holds implications for the adult. However, an individual's perception of the past and

present, accurate or not, plays a role as well, potentially influencing both prophecies of risk and their fulfillment.

**Key points**

**What’s known**

- Adverse childhood experiences (ACEs) have been associated with increased risk for later-life disease/dysfunction using adults’ retrospective self-reports of ACEs.

**What’s new**

- We replicate past findings using both retrospective and prospective measures of ACEs to predict poor adult outcomes in a longitudinal birth-cohort.
- In comparison to prospective ACE measures, retrospective ACEs showed stronger associations with outcomes that were subjectively assessed (i.e., through self-report) and weaker associations with outcomes that were objectively measured.
- Beliefs about childhood adversity predicted subjective outcomes regardless of whether adversities were prospectively recorded.
- “Forgotten” adversities still predicted objective outcomes.

**What’s clinically relevant**

- “Sunny” and “grey” dispositions may bias predictions from retrospective ACE measures toward underestimating ACE impacts on objectively-measured outcomes and overestimating impacts on subjectively-measured outcomes.
- Predictions of health risk based on retrospective ACE reports should utilize objective outcome measures; when these are difficult to obtain, correction factors may be warranted.

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Tables and Figures

Table 1. Health and Social Outcomes

Subjective		Objective
Domains		
Physical Health	<p><i>Self-rated poor health</i></p> <p>Self-rated poor health was measured at age 38 by a 5-point scale in response to the question: “In general, would you say your health is?” Response options were “poor,” “fair,” “good,” “very good” or “excellent”. (Idler &amp; Benyamini, 1997).</p>	<p><i>Biomarker-indexed poor health</i></p> <p>Biomarker-indexed poor health is an objective measure of physical health taken by summing nine indicators of physical health measured at age 38 including metabolic abnormalities (waist circumference, high-density lipoprotein level, triglyceride level, blood pressure, and glycated hemoglobin), cardiorespiratory fitness, pulmonary function, periodontal disease, and systemic inflammation. Details are provided in Israel et al. (2014).</p>
Cognitive Health	<p><i>Complaints of cognitive impairment</i></p> <p>Study members reported at age 38 how often in the past year (never, sometimes, or often) they experienced problems with, e.g., keeping track of appointments, remembering why they went to a store, repeating the same story to someone, multi-tasking, thinking when the TV or radio is on, word-finding difficulty, among other items based on symptom criteria for DSM-IV Mild Neurocognitive Disorder. Scores on the 19 questions were summed (score range = 0 to 31; mean (SD) = 9.1(5.3); internal consistency reliability = 0.83). The complaints score was converted to a Z-score, mean = 0, SD = 1 (Moffitt et al., 2015).</p>	<p><i>Working memory performance on the WAIS-IV</i></p> <p>Working memory performance was assessed at age 38 through the Working Memory Index of the Wechsler Adult Intelligence Scale –IV (WAIS-IV) (Wechsler, 2008).</p>
Mental Health	<p><i>p-factor of General Psychopathology</i></p> <p>Our measure of poor mental health is a general factor of psychopathology, the p-factor, derived from confirmatory factor analysis of symptom-level psychopathology data collected in the Study population between ages 18 and 38. Every 2 to 6 years, Study members were interviewed about past-year symptoms of DSM-defined disorders by trained non-lay interviewers. Details on the p-factor are provided in Caspi et al. (2014).</p>	<p>Our study includes no objective measures of mental health as there are no lab tests for mental disorders.</p>
Social Health	<p><i>Poor Partner Relationship Quality</i></p> <p>Poor partner relationship quality was assessed at age 38 through a 28-item survey about shared activities and interests, balance of power, respect and fairness, emotional intimacy and trust, and open communication (<math>\alpha = .93</math>) (Cerdá et al., 2016).</p>	<p>Our study includes no objective measure of partner relationship quality as this is generally measured only through self or partner/informant reports. Given the late onset of marriage and high rates of de-facto relationships, divorce is not a useful objective indicator of poor relationship.</p>

**Table 2.** Correlation and agreement among prospective and retrospective ACE measures (N=950).

ACE	Correlation	Agreement
	<i>Pearson's r</i>	<i>Weighted Kappa</i>
<b>Child Harm</b>		
Physical abuse	.07*	.07
Emotional abuse	.03	.02
Physical neglect	.14***	.13
Emotional neglect	.07*	.07
Sexual abuse	.10**	.03
<b>Household Dysfunction</b>		
Family member incarceration	.16***	.14
Household substance abuse	.22***	.16
Household mental illness	.16***	.15
Loss of parent	.83***	.83
Household partner violence	.11**	.10
<b>Total ACE count</b>	<b>.47***</b>	<b>.31</b>

Notes. \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ .



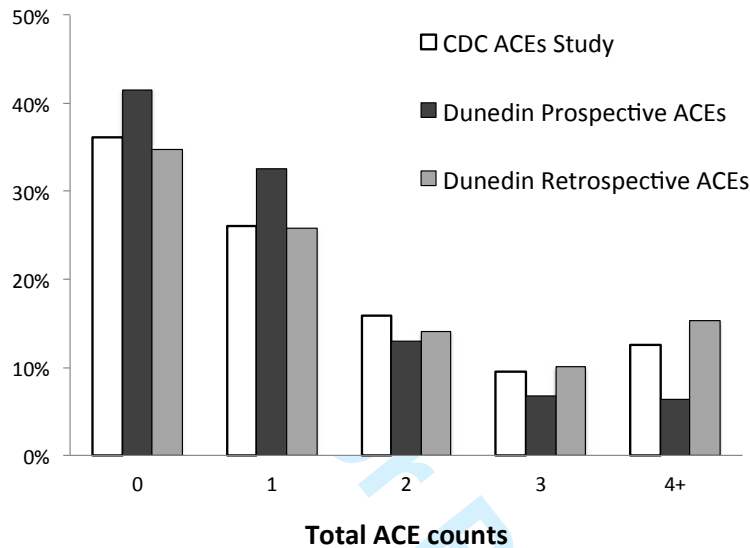
**Table 3. Associations of prospectively-recorded and retrospectively-reported counts of adverse childhood experiences (ACEs) with physical, cognitive, mental, and social health outcomes by age 38.** The table shows that both prospective and retrospective ACEs are related to poorer outcomes by midlife (white columns). Prospective ACE associations with all self-reported outcomes dropped to non-significance after adjusting for retrospective ACE counts while the associations with the objectively-measured outcomes remained (first gray column). Retrospective ACE associations with all self-reported outcomes remained after adjusting for prospective ACE counts while the associations with the objectively-measured outcomes dropped to non-significance (second gray column).

			Prospective ACE counts		Retrospective ACE counts	
			Unadjusted	Adjusted for Retrospective ACE Counts	Unadjusted	Adjusted for Prospective ACE Counts
<i>N</i>			<i>Effect size (Pearson's r)</i>		<i>Effect size (Pearson's r)</i>	
<i>Self-reported Outcomes</i>						
<b>Physical Health</b>						
Self-reported Poor Health	950		.13*** (.07, .20)	.05 (-.02, .12)	.18*** (.12, .24)	.16*** (.09, .23)
<b>Cognitive Health</b>						
Self-reported Poor Memory	946		.11** (.05, .17)	.06 (-.01, .13)	.13*** (.06, .19)	.10** (.03, .17)
<b>Mental Health</b>						
Self-reported Psychopathology (clinical interview)	950		.23*** (.16, .28)	.05 (-.02, .12)	.40*** (.34, .46)	.38*** (.31, .44)
<b>Social Health</b>						
Self-reported Poor Relationship Quality <sup>1</sup>	844		.11** (.04, .18)	.01 (-.07, .09)	.21*** (.14, .27)	.20*** (.13, .28)
<i>Objectively-Measured Outcomes</i>						
<b>Physical Health</b>						
Biomarker-derived Poor Health	920		.11** (.04, .17)	.09* (.02, .16)	.08* (.02, .15)	.04 (-.03, .11)
<b>Cognitive Health</b>						
Poor Tested Working Memory	938		.15*** (.09, .22)	.15*** (.08, .23)	.07* (.01, .13)	.00 (-.07, .07)

Notes. \*p < .05, \*\*p < .01, \*\*\*p < .001. All analyses were conducted controlling for sex. 95% confidence intervals for the effects are reported in parentheses. Effect sizes may be compared at <http://quantpsy.org/corrtest/corrtest2.htm>.

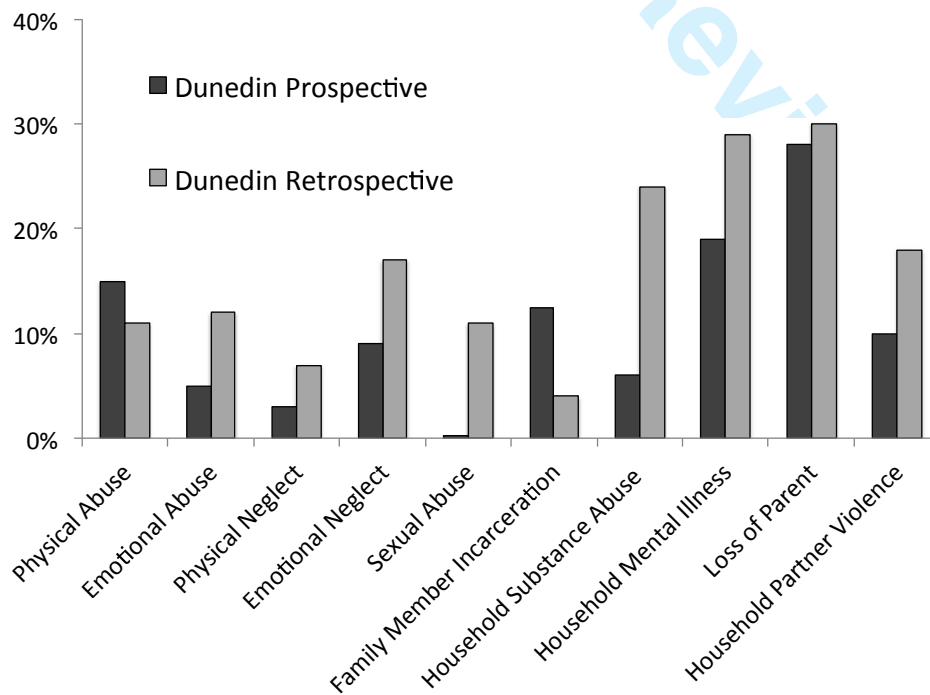
<sup>1</sup> Relationship quality was not obtained for 105 Study members who had no partner within the past year.

**Figure 1A.** Distribution of ACEs in the Dunedin cohort, recorded prospectively and retrospectively, with comparison to ACE distributions reported in the CDC ACEs Study.<sup>1</sup>

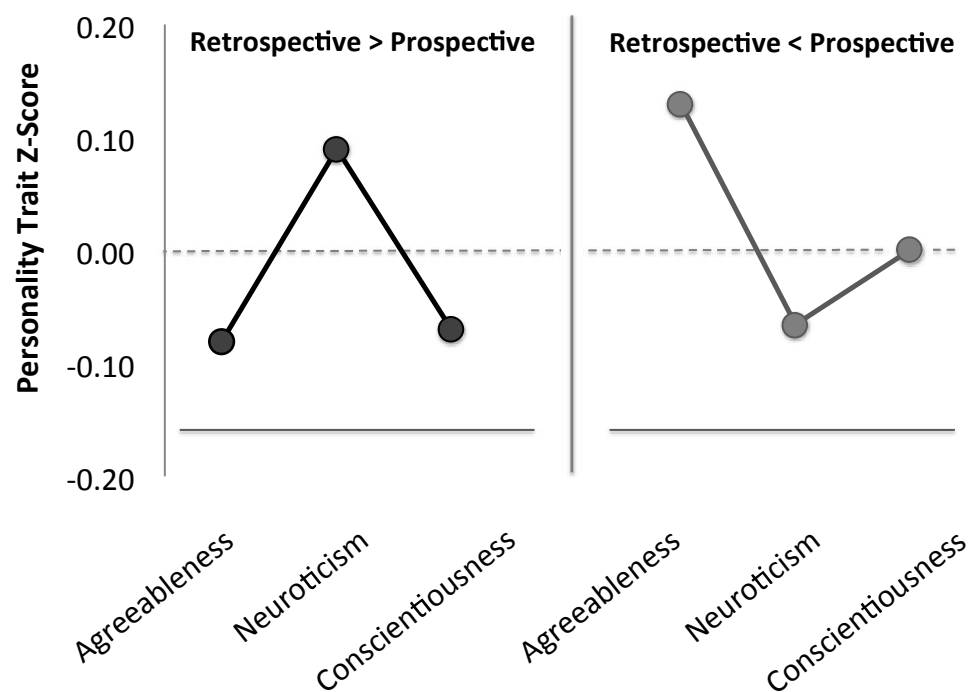


Notes. <sup>1</sup>Distribution of ACEs in the CDC ACEs Study from Table 1 of Felitti et al. (1998, p. 248).

**Figure 1B.** Prevalence of individual ACEs in the Dunedin cohort, as recorded by prospective and retrospective measurement.



**Figure 2.** Personality characteristics of individuals who recall more or fewer ACEs than were recorded in their prospective records.



*Notes.* “Retrospective > Prospective” represents individuals who recalled more ACEs than were prospectively recorded (N = 384) and “Retrospective < Prospective” represents individuals who recalled fewer ACEs than were prospectively recorded (N = 209). Analyses reported in the text are based on the complete distribution. Group means in the figure are adjusted for sex.

## Supplementary Materials

**Table S1a. Cross tabulation of retrospective and prospective ACEs in the Dunedin cohort.** Green cells show the number of Study members with perfect agreement between retrospective and prospective ACE counts at each possible count total (N=357). Blue cells show the number of Study members whose retrospective counts exceed their prospective (N=384). Orange cells show the number of Study members whose prospective counts exceed their retrospective (N=209).

		Retrospective ACEs				
		0	1	2	3	4 or more
Prospective ACEs	0	213	99	44	18	20
	1	95	87	53	35	39
	2	15	37	20	18	33
	3	4	15	11	9	25
	4 or more	3	7	6	16	28

Notes. Cell values are N's.

**Table S1b. Percent of Dunedin cohort showing agreement and disagreement between retrospective and prospective ACE measures.**

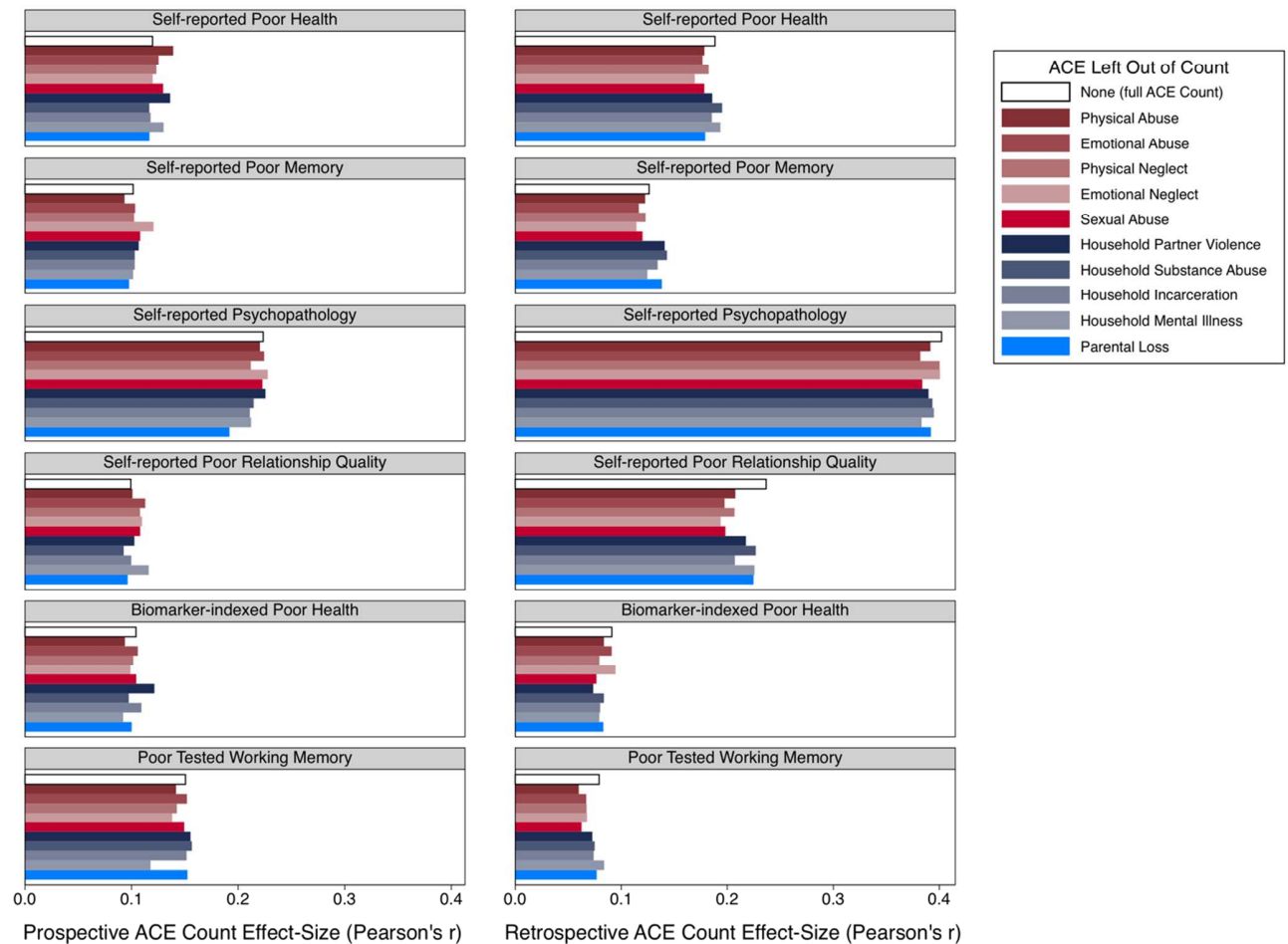
Level of Agreement between ACE Measures	N	Percent of cohort
ACE measures agree	357	37.6%
Prospective greater by 1	159	16.7%
Prospective greater by 2	36	3.8%
Prospective greater by 3	11	1.2%
Prospective greater by 4	3	0.3%
Retrospective greater by 1	195	20.5%
Retrospective greater by 2	112	11.8%
Retrospective greater by 3	57	6.0%
Retrospective greater by 4	20	2.1%

**Table S2. “Leave-one-out” correlation and agreement among prospective and retrospective ACE measures in the Dunedin cohort.** This table presents the correlation and agreement between total retrospective and prospective ACE counts (first row) and the same statistics with each category of adversity iteratively removed from the count of total retrospective and prospective ACEs (rows 2-11). The results show that prospective-retrospective agreement depends on high agreement about parental loss.

	Correlation	Agreement
	<i>Pearson’s r</i>	<i>Weighted Kappa</i>
<b>Total ACE count</b>	.47***	.31
Without physical abuse	.49***	.32
Without emotional abuse	.47***	.32
Without physical neglect	.45***	.30
Without emotional neglect	.48***	.32
Without sexual abuse	.46***	.32
Without family member incarceration	.45***	.28
Without household substance abuse	.45***	.30
Without household mental illness	.49***	.34
Without loss of parent	.30***	.19
Without household partner violence	.45***	.32

## ACEs &amp; Adult Health

**Figure S1. “Leave-one-out” bivariate correlations between ACEs and outcome measures.**  
 These figures depict the finding that leaving-out any one category of ACE from our bivariate correlation analyses did not significantly change the results.



*Notes.* Tiled figures depict bivariate correlations between ACEs and outcome measures in our study with: a.) All ten categories of adversity included in the ACE count (white bar) and b.) All types of adversity included in the ACE count save one category (colored bars). Each colored bar in the tiled figures thus represents the correlation between counts of nine forms of childhood adversity and the adult outcome listed in the tile header.